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Lisa Sutherland and Lea Geiger – Safer Infant sleep: A Shared Responsibility

Helen Ball:

Lea is a provincial clinical coordinator for Maternal Infant Health and Perinatal Services in British Columbia, providing leadership support and coordination for the strategic planning of perinatal services less over 28 years of experience in maternal infant care and is also an Ivy Salesy Lactation consultant and Pascoe Chair of the Breastfeeding Committee for Canada Baby Friendly Assessment Team. Past co-chair of the British Columbia Provincial Territorial Baby Friendly Implementation Committee and past member of the British Columbia Board of Directors. Lea is a baby friendly initiative assessor for the Breastfeeding Committee for Canada. Last co-presenter is Lisa Sutherland. She's a midwifery lead for Perinatal Services and a registered midwife. And again, I've also lactation consultant and she has a clinical faculty appointment in the Faculty of Medicine at the University of British Columbia. She's previously served as head of midwifery at St Paul's Hospital in Vancouver and a board member of the Midwives Association of British Columbia. Their talk is going to discuss a jurisdiction wide approach to the implementation of a new resource developed by Perinatal Services of British Columbia called Safer Infant Sleep, which implements a risk minimisation approach to suicide prevention, which is something that we've long researched and advocated for in our own research and outreach. So Leah and Lisa

Lisa Sutherland and Lea Geiger:

Thank you. We're very honoured today to be presenting alongside our esteemed colleagues at the Durham Infants and Sleep Centre Conference to celebrate the 20 plus years of work that has been very influential in improving safer sleep practises internationally and including our jurisdiction.

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British Columbia, Canada, We would like to start our presentation with a land acknowledgement at their core line acknowledgements or verbal or written statements that formally and publicly pay tribute to the original indigenous inhabitants of the land. We thank the members of the Musuem, Squamish, and say the two territories on which perinatal services BC resides to allow us to do our important work in maternal newborn health.

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We acknowledge them as the original people of the land and also acknowledge the traditional lands and territories throughout British Columbia and which our many colleagues work, live and play. And today I'm humbled to work and live on the beautiful lands of the unceded territories of the Secwepemc Nation, which is in the interior of British Columbia. And my colleague Lisa lives and works on the Unceded Territories, traditional territories of the Comox Nation We would like to invite you to also acknowledge the traditional and territory lands of which you are situated.

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We'd also like to take this opportunity to express our deepest condolences to all the families who have lost a baby. Death was a profound loss to the families, friends, and those affected by the death of their baby. Our colleague Lucy Barney, who is the Perinatal Services B.C. Indigenous Lead, speaks about how when we lose a baby, they become our elders and we need to honour their teachings to ensure safer sleep outcomes for all babies.

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Today, we'd like to provide an overview of our presentation, and it will focus on our jurisdiction wide approach to safer infant sleep practises as a shared responsibility. We'll be describing our knowledge translation journey from evidence to practise. Specifically will be providing an overview of our updated Safer Sleep Resource using a family centre, trauma informed and culturally safe approach to infant safer sleep practises.

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We'll be reviewing the key messages and support tools that have been developed within the resource and exploring key messages and support tools and how they may be used in practise. To help facilitate and encourage an open discussion with parents and caregivers on infant safer sleep practises. Before moving forward, I would also like to make a note on gender inclusion during our presentation and through our resource that has been used.

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Purnell Services, B.C. recognises that using gender inclusive care optimises pregnancy and birth outcomes, we refer to women and or pregnant individuals and parents or caregivers to respectfully demonstrate our commitment to gender inclusive and gender affirming care for two separate transgender and non-binary individuals. We acknowledge that breastfeeding is traditionally

understood to involve an individual of the female sex and gender identity who also identifies as a woman and a mother.

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However, it's really important to recognise that there are individuals in a parent parenting and human milk feeding relationship with a child who may not self-identify as such and who may prefer to use the term breast feeding rather than breastfeeding We have no disclosures. We have no association with any companies or commercial entities that may have an impact on our subject matter.

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For the portion of our presentation We'd like to start this conversation by acknowledging the complexity, but sharing is a complex issue that may occur potentially or unintentionally, and the research indicates that accidental bed sharing can ultimately be more dangerous than when done intentionally in a safe environment. Health care providers play a critical role in the way that they approach conversation about bed sharing, working towards eliminating stigma, stigma around bed sharing, and educating all families or caregivers about safer sleep practises have the potential to reduce unexpected infant sleep related deaths.

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As part of our partnership and promotion of this we need to also think about how balancing stakeholder desires and expectations with requirements, understanding them, valuing diversity, and in understanding the determines of health turnover. My colleague Lisa now, who's going to provide you some context as we move through our presentation, will share aspects of our context here that have influenced our safer sleep messaging.

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In April of 2019, the BC Coroners Service convened a death review panel with the purpose of reviewing unexpected infant death during sleep over a six year period ending in December 2018. During that time there were 141 infants who died in British Columbia suddenly and unexpectedly during sleep.

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The findings from that review panel were the following that infants continue to die under the same circumstances as in the previous death reviews. That the deaths of infants were found disproportionately amongst young families and those experiencing vulnerabilities. And that sleep position, combined with health issues, may have increased the mortality for some infants The BC Coroners Service investigation found that accidental causes from overly asphyxia and falls from sleep surface resulted in 25% of these deaths.

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Natural disease, pneumonia and other respiratory infection, along with anomalies, resulted in a further 25% of the deaths. And the 69 remaining deaths stayed undetermined at the time of the publishing of the report, with 42 still under investigation. The table on this slide describes the unsafe sleep practises or identified during those reviews. Unsafe sleep practises were identified in 81% of the cases and with some infants experiencing multiple.

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This list represents the modifiable factors that we aim to address over the course of developing and disseminating our resource. Following the coroner service review and findings that we needed to strengthen our safer sleep messaging and provide targeted messaging for vulnerable families, we embarked on a process of updating our 2016 resource and messaging The update process was rigorous, involving a jurisdictional scan literature review, and we had a rapid response report prepared by Carter, which is our Canadian Agency for Drugs and Technologies in Health, and they support organisations to do literature reviews and include great literature in that we conducted a survey to explore the health care providers needs for information related to sleep and to explore any

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gaps in our 2016 resource, incorporating the Coroner's feedback to focus on vulnerable families and the review work we've done to date, we identified the need to stratify into two different populations our messaging, the healthy term, breastfed infant and those infants experiencing risks and vulnerabilities as we'll explore further in our presentation. In addition, we have other sleep related resources to review and alignment, including a patient facing one developed by our Ministry of Health and a First Nations Health Authority resource called Honouring Our Baby's Safer Sleep Toolkit.

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And we'll show you more about that one as well.

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Following all the review process, we developed a list of areas to update and areas for new content. So this slide describes the areas that we strengthen in our resource. We strengthen the messaging around the continuum of care and the role of health care providers across the entire continuum to discuss safer infant sleep We developed a safe, safer sleep surface decision.

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Eight. We strengthened our messaging around bed sharing and our messaging around swaddling and provided additional guidance for commercial products along with lost bags and cradle boards. Another daytime sleep items new sections for our work included addressing the changes in terminology as a strengthening considerations for indigenous families, exploring the risk of forced safer sleep and sudden unexpected infant death.

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Which have explored healthy infant sleep as well as commercial sleep training programmes, and developed an infant sleep discussion guide And before we go any further, we'd like to take a pause and just explore some of the key terms that we've used in our resource. Many of these will be familiar to you, but I'm sure you'll also know that there's a lack of standard definition for many of these in the literature and how they're used around the world.

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Bed sharing we define as a parent or caregiver, sleeping on the same sleep surface as their infant. And we further elaborate that that is distinct from SOFA or recliner armchair sleeping. That's not a safe sleep surface. And it's also distinct from solitary sleep, where the infant is in the same room or so, where the infant is in a different room and then room sharing where the infant is in the same room, but on a different sleep surface where sleeping is a term we've added to our resource for the first time.

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And we describe it as an interconnected relationship between breastfeeding and sleeping amongst healthy term breastfed infants. Co-sleeping is a term, in fact, we don't use in our resource. It is commonly used by health care providers and families alike in our context. However, there's a lack of standard definition around this term, both in the literature and in how families use it.

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So to avoid that ambiguity and the risks that that can present. We have avoided using this term and we ask health care providers to ensure that when they're using the term with families or families, engage with that term to please seek clarification on what they in fact mean. Inform. Sure. Decision making is strengthened in our resource, and we will share that further with you and why we've included that.

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And then, sudden, unexpected infant death during sleep is an umbrella term used by the B.C. Coroners Service to refer to all unexpected infant deaths that occurred during sleep as a result of undetermined or accidental causes as well as natural causes. And we use this term throughout our resource, the coroner's service explains that this classification supports public health prevention efforts to address modifiable risk factors by using death classifications of undetermined accidental or natural.

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We can better understand causes and focus our prevention efforts for the remainder of our presentation. We'll be focussing on providing an overview of the ATC for infant sleep practise key messages found throughout our resource. Key Message one focuses on safer sleep principles. While there's no one practise, that completely eliminates the risk of sudden, unexpected infant death during sleep, there are evidence based recommendations that health care providers can share with families and caregivers to help guide their safe, to guide their infant sleep position, environment and surface with safer sleep.

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Options for every sleep or updated resource provides guidance on the recommendation that conversations about infants sleep are encouraged to occur using a harm reduction approach that is person centred and family centred treatment form and culturally safe to reduce the risk of harm and promote evidence, inform safer sleep practises. We know the one size fits all approach is unrealistic and does not align with the harm reduction and family centre approach.

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There are several tables that have been developed in the resource to support the conversation between health care providers and the parent or caregiver. This table, for example, provides main considerations when discussing principles for safer sleep with parents or caregivers. Sleep environments. Sleep position and sleep surface. We have stratify the at risk and healthy term. Breastfed infant in stable locations are not safe or unsafe by definition.

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The space is should be flat, firm and free of products that will have for breathing. A parent's responsiveness is of critical importance. They need to be able to respond and be aware of their child. The next key message focuses on the importance of the social determinants of health. Seven in infants, death during sleep can happen to any infant in any demographic, but these deaths are more often seen in infants and families experiencing vulnerabilities Vulnerable families are defined in our resources as those who experience a larger burden of illness and distress than others.

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A number of factors may influence vulnerabilities as we know. And for this reason, our safe sleep messaging is recommended to be introduced in a context that recognises the impacts of the social terms of health on the infant's overall health Health inequities may result in circumstances in which the infants are at greater risk for injury, illness and death, including sudden, unexpected infant death.

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During sleep. Infant sleep environment may be influenced by parents or caregivers. Limited access to prenatal and preventive health care. Lack of awareness regarding safe, safer sleep practises, poor social support systems, or their daily living conditions may be impacting them. Making safe sleep practise decisions such as the lack of the infant's own sleep service or even overcrowding. We know that social determinants of health do not influence individuals in isolation.

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Rather, these factors combine in a unique way that are complex, interdependent and bidirectional, creating a cumulative effect when they interact. Our updated resource reflects a personalised relationship building approach. This shift represents a significant improvement in how our safer sleep discussion is implemented with all families and individuals and those who are experiencing vulnerabilities We've also included considerations for our indigenous infants within our resources.

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Indigenous infants are disproportionately impacted by sudden, unexpected infant death during sleep, and in Canada, Indigenous infant mortality rates are more than twice as high. The reasons for higher rates of sleep related infant death in the indigenous communities are complex, and due to the historical experiences of the imposition of the Indian Act that took away any self-determination in indigenous peoples.

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Once experience, the force of indigenous people to intent attend Indian residential schools. Now the 60 schools are just a few examples that are intergenerational experiences. Say for instance, sleep practise shifts must be undertaken at both the individual and organisational levels and in collaboration with the indigenous peoples recognising respecting their cultural needs, preferences and priorities. Are updated. The resource strengthened the content and includes the principles and approaches for culturally safe care and least is going to be expanding on this later in our presentation.

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We know the lack of culturally appropriate support may further impact parents or caregivers in seeking support related to safer infants. These practises and this. This ultimately increases risk and further adds to health inequity.

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Indigenous people have had multiple losses, and these losses help us to understand why Indigenous babies may be exposed to more of their risk factors for sudden, unexpected infant deaths during sleep. Key Message three Describing risk for infants. The intersecting factors that increase the risk of sudden unexpected infant death during sleep the triple risk model was developed by Philip Kenny in 1994 as a means of describing the overlapping factors that can increase the risk for sudden unexpected infant death during sleep.

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This model is included in our resources to both increase health care provider understanding and to provide a framework for having these discussions with families as further information in the table on the following slide to describe these three overlapping factors pre-existing risk factors are such things as prematurity, low birth weight and prenatal substance use exposure. Infants in the critical development period or those between zero and 12 months with a peak of risk between two and four months, and infants experiencing exhaustion.

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Stressors are those, for example, who are placed, prone or in a sideline position, placed on a soft bedding, mattress or pillow, and those whose face becomes accidentally covered by loose bedding or loose swaddle and those exposed to tobacco smoke. Safest seat planning with families will take into account all of these considerations Key Message four discusses the important role of the health care provider and having conversations about safer infant sleep practises and normal infant sleep biology.

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Initiating conversations early in the prenatal discussion is especially important given the bed sharing is a fairly common practise. According to the data from the Canadian Community Health Survey, one third of mothers indicated their last child shared a bed with them or anyone else every day or almost every day. When the child was under 12 months of age.

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Safe sleep messaging is shared responsibility as a theme of our presentation. The literature highlights that the values, attitudes and beliefs of the health care provider about safer infant sleep practises can significantly impact the way families share or discuss their sleep practises. Health care providers play an important role by having repeated safer sleep conversations during the preconception pregnancy and postpartum period.

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Repeated conversations can create really amazing opportunities for the health care provider to support families in making informed choices regarding their infants safer sleep practises. Our hope is that the resource for clinical practise when working with individuals or families provides the evidence based tools to start the conversation and how to create opportunities to build relationships to have an open and non-judgmental conversation Providing anticipatory guidance for parents or caregivers on how to help their infant sleep well and safely should also place emphasis on normalising infant sleep behaviour while taking into account the social context of the family.

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It is important to engage parents and caregivers in a balanced conversation about the risks and the benefits of different sleep practises, while acknowledging the social and cultural context in order for them to make a safer sleep decision. Parents are so exposed to messaging that infants should sleep throughout the night, and as this is biologically unlikely for an infant, can result in parents interpreting it as a sleep problem and maybe experience as a parent failure.

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Lisa is going to be speaking a little bit further to this under the mental wellbeing and parenting section of our presentation In the new resource we have provided implementation guidance tools. The Infant Sleep Discussion Guide found in the resource was developed to support health care providers with informed decision discussions on the safer options for infant sleep based on the parent or caregiver circumstances.

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It also helps provide anticipatory guidance in the prenatal period on infant sleep, providing anticipatory guidance around what to expect in those first early days as breastfeeding is being established and the importance of frequent night feedings and waking as protective And it also provides guidance for the first year and strategies to increase the parents and caregivers mental wellbeing The key message five is focussed on breastfeeding as a protective factor.

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Our messaging has greatly shifted and no longer presents bed sharing as a risk for all babies within our jurisdiction. We have applied the harm reduction approach similar to our approach with other complex issues Breastfeeding is a protective factor for sudden, unexpected infant deaths during sleep, regardless of the sleep arrangement.

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When we look at the evidence, many of us may be familiar with the 2020 recommendation that came out from the academy breastfeeding medicine, and I know that there's been a presentation on that and it supports there is a risk reduction or no increased risk to the healthy term breastfed infant when bed chair and breast sleeping. In the absence of the risk factors as outlined in the triple risk model that Lisa just discussed We know families are breastfeeding longer and that is our public health messaging and the importance of it.

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So breast sleeping is a reality. A longitudinal study by Helen Ball found that breastfeeding families were twice as likely to be bed sharing compared to those families that were not breastfeeding. Discussing the concept of breast sleeping with a breastfeeding family allows a way to discuss a safer bed sharing practises and reframe the messaging that bed sharing needs to take into account and appropriate guidance, appropriate guidance, balancing risk minimisation with supporting the breastfeeding dyad, especially given the long term health outcomes for both the breastfeeding parent and the child.

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When we are discussing the protection, protective factors of breast sleeping which is a new term, as Lisa said and as mentioned that in the beginning, in our new terms it's actually not a new term. It was coined by McKenna and get it back in 2015. But using the term breast sleeping is a plausible way to remove the negative connotations of bed sharing and redirect ongoing data driven discussions and education about best practises around breastfeeding and sleep.

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Breastfeeding is a physiological act and we know it changes the nature of sleep. This is a critical factor for safer sleep in the circumstances of bed sharing and it's likely due to the increase arouse ability and attunement of the breastfeeding dyad. And we can see that in the literature supports that the mother and the child's sleep cycles and cortisol levels are often in sync and the protective factor also may be related to the position which most breastfeeding parents naturally sleep.

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The protective seat or cuddle curl. You might be familiar with that in which they make a safe space for their baby to sleep with their bodies and this can be prevented. Suffocation and overheating breast sleeping also protects the breastfeeding duration for both the short and long term health outcomes of the dyad. We know that breastfeeding more than six months is protective exclusively breastfeeding slightly more protective.

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And we also know that breastfed babies wake more frequently before four months, which is around the two to four month time period. When research notes that babies are at higher risk after that night, waking is the same frequency as former Fed babies. And this is a positive health messaging that we can share with the families that we care for.

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That infant self arousing with frequent night waking is protective in normal This table was developed to present the safety information for bed sharing. One of the key aims of this harm reduction messaging that we've developed is to avoid unintended consequences from the universal messaging that parents and caregivers should not venture. We know this is unrealistic and we do want to emphasise that bed sharing in the context of safer sleep is distinct from sofa and or reclined recliner sharing, and that confers the greatest risk.

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This table provides providers with information on how to guide conversation in order to help families or caregivers make an informed decision about their infant sleep position within the resource. We provide several tables in this safety information for bed sharing is encouraged to be shared in conjunction with Safe Sleep Principles, with the intention of supporting a safer sleep environment and to protect the breastfeeding relationship The next table provides guidance for the health care provider related to factors that may significantly increase the bed sharing risk for the healthy term.

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Breastfed Infant. If parents or caregivers have one of these risk factors, it's recommended suggests other sleep surface options and discuss how best to support the families to reduce their risk. One of our recommendations is that if a parent has never breastfed, it is safer for the infant to sleep on their own. Sleep surface in the parents room than to bed chair.

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I think it's really important for us to understand the why and that bed sharing with formula feeding does not offer the same protection bed sharing with breastfeeding, as I discussed, does not confer the same risk. For me, the Fed families may be more likely to put their infants on a pillow and infant is more likely to be placed prone.

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The sleep cycles may not be in sync as well, and both may be less reliable. And all of these factors may increase risk. We do want to acknowledge that there is a gap in the evidence on the recommendation for mixed feeding. There is not enough supportive evidence for us to have included information on mixed feeding in our resource.

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We also want to emphasise that. We want to make sure that we are equipping our families with information to mitigate risk in the event that bed sharing occurs unintentionally and also and also have the risk factors that place them at further risk for sudden, unexpected death during sleep. And we know that unintentional bed sharing does occur. We've provided health care provider with the guidance on how to provide non-judgmental counselling as this helps to build that trusting patient professional relationship for both disclosure and effective counselling and improved outcomes Another implementation guidance tool that we've created is called the Safe Sleep Surface Decision Aid for health care providers.

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And its help, it's it was developed to help inform shared decision discussions on the safer options for infant sleep based on the parents and caregivers circumstances. Health care providers are encouraged to use this decision aid in conjunction with the Safer Sleep Principles to support engaging parents and caregivers in a shared, informed, decision making conversation regarding their infant sleep surface.

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And this tool also helps to promote a consistent evidence based approach to to the discussions. Key Message six speaks to the principles of practise that inform our resource personal centred harm reducing culturally safe and trauma informed. This approach to practise is supported within our context of integrating these principles to address other complex issues. We are on the sixth year of a public health emergency, which is an overdose crisis, with over 2000 people dying of overdose and drug toxicity.

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Last year and 9000 people since the beginning of the crisis. The BC Centre for Disease Control believes that harm reduction is essential to preventing and reducing the undue health, social, economic harms of substance use The framework of shared decision making is included as additional implementation guidance to support putting those principles into practise with informed decision making the patients are partners in their health care and the goals of integrating this model include improving the quality of the decision making, reducing the rates of infant sleep related death, and supporting families to achieve their feeding goals.

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Shared decision making is based on the principle that the person self-determination is an essential part of their health care, and it's a process that requires collaboration between the person the patient and their health care provider. The image on this slide helps to illustrate the difference between the historical approach to decision making with a clinician tells the person essentially what to do and seeks only minimal consent in a shared decision making process.

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It incorporates both the clinicians experience, the evidence their clinical judgement, along with the person's values and beliefs and their family circumstances.

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You can see from the diagram as well that it's a circular, an entire process that's taking into account an ongoing conversation where decisions can change The decision will sometimes end with the person making the final decision and sometimes end with the clinician making the final decision. The goal is not that there's a shared final decision, but that the entire process strengthens the quality of that decision making over time.

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And on the next slide. We speak to additional resource development context, which is the along story with the BC Coroner's Report and the opioid crisis, which is the context of colonisation anti-indigenous racism and health care inequities that resulted Therefore, our updated resource to strengthen the content in this area. It includes principles and approaches for culturally safe care, which were developed in collaboration with partners and stakeholders and published in another one of our resources called Honouring Indigenous Women's and Families Pregnancy Journeys A Practise Resource to support improved perinatal care.

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And you'll see the principles there on the slide principle one Cultural Safety and cultural humility ensuring that patients are receptive to care because they feel supported and safe, and that health care providers recognise the limits of their own understanding and seek guidance from their patients to self-determination. Explaining options for the patients can make informed decisions about their treatment on their care.

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Three. Trust through relationships. Fostering a connexion built on trust. Respect demonstrating an understanding of and a respect for traditional practises and knowledge. anti-Indigenous Racism speaks to building awareness of overt and covert racism and developing policies and practises to address racist incidents and strength and resilience based practise is promoting positive outcomes by focussing on a person's strength honouring our baby safely.

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Toolkit is an infant resource developed in collaboration with the First Nations Health Authority, and that's a health authority that is province wide that plans, designs and manages and delivers health services for First Nations people in British Columbia. The resource was developed to provide culturally safe information to indigenous families on safer infant sleep. The toolkit is designed with images on cards, and those cards are used to guide a conversation with family to have an interactive, family centred approach.

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The principles of safer sleep in this resource align with the other infant sleep resources in our province.

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There's an image on the slide showing one of the cards and a family interacting, and the cards illustrate different sleep situations to foster the conversation around what a family might do in a certain situation. The four arms framework on the slide speaks to how to put this culturally safe practise and principles into your practise. Using this for our framework of respect, respecting indigenous people for who they are relevant Providing Indigenous people the information that is relevant.

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Reciprocity. Encouraging reciprocity in the health care relationship and responsibility. Enabling Indigenous peoples to exercise responsibility and agency over their own health care Our key message seven discusses swaddling, and we have updated and expanded the swaddling content to reflect the current evidence that routine swallowing practises for sleep is not recommended in most circumstances. Evidence highlights the risk was much greater when infants were swaddled and placed on their sides nearly doubled and even more when infants were swaddled in on their stomachs.

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The risk was higher for the babies who were at least six months old. Our messaging targeted different population ins with an emphasis on harm reduction and shared decision making. For example, we also recommend not swaddling after two or three months or when the baby show signs of rolling The key messages that routine tight swallowing is an unsafe sleep practise that may increase the risk of overheating and may increase the risk of sudden, unexpected infant death during sleep, chest infections and development or exacerbation of the hip of hip dysplasia.

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In addition, the resource has messaging around that swaddling may lead to less breastfeeding, which may also be associated with greater weight loss, more jaundice, and a delay in milk production. We do know that for some populations such as the preterm and substance exposed newborns that they may require swaddling as part of the developmentally appropriate care. However, we do emphasise that the importance of the provider educating families that is not recommended to be continued after discharged from the hospital and this is related to the increased association with a higher risk

of sudden, unexpected infant death during sleep in this population, as we've previously discussed and outlined in the triple risk model So this has been an important

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this is an important practise shift actually in our jurisdiction and it might be the same for yours. Health care providers really do play a very important role in implementing this risk minimisation strategy and emphasising we're not modelling the swaddle. This practise recommendation is ideally best shared across a continuum of care starting in the prenatal period. Health care providers are encouraged to have an open discussion with parents and caregivers about swaddling their infants and the recommendations related to that to help empower families to make informed decisions that meet their cultural preferences and values and needs.

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And so what does this new information mean to the sleep deprived new parent and how best can providers support families? This swaddling harm reduction approach safety information table outlines those that specific guidance. And for families who have made an informed decision to swaddle for cultural or other reasons, we are encouraging providers to offer families the information that has been listed on this table.

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To provide guidance on how to practise safer swallowing or loose bundling. And we recognise that this is just one part of how to support safer sleep. And another way is to ensure parents have access, timely access to the supports and service they need and those critical early days. We've also provided guidance on commercial products related to infant sleep, such as sleep socks, weighted blankets, wedges and positions.

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We've included some guidance for slings and wraps and carriers. Most bags, as these are used by parents and caregivers for daytime sleep. In addition, we've develop safety information for pacifier use and it's included as there's emerging evidence that pacifier use may be potentially protective against sudden, unexpected infant death during sleep. However, the physiological basis for this is yet unknown.

00:37:42:24 - 00:38:04:09

Unknown

We placed emphasis on the importance of establishing breastfeeding and seeking breastfeeding support as needed in the early days. Key message eight speaks to promoting wellbeing and mental health for parents and caregivers, parents who are well supported or better able to adapt to normal infant sleep and feeding behaviours. And are better able to incorporate safer sleep practises for every sleep.

00:38:05:00 - 00:38:31:22

Unknown

Parental wellbeing and increased understanding of normal sleep behaviour for infants are important in light of all the societal pressures they experienced for infants to sleep independently and that their infant should be sleeping through the night without adult support to fall asleep or stay asleep. As part of the wellbeing conversation, we know that many families are seeking information about sleep training to address their concerns about their infant sleep behaviour and to address their fatigue.

00:38:32:22 - 00:39:12:08

Unknown

We discuss sleep training further in our resource and describe how there is no evidence showing that sleep training programmes are safe for infants less than six months of age, as our guidance does not align both with the biological norms of infant feeding and sleep. And with the recommendation for room sharing, as many rely on solitary sleep as part of the sleep training programme, We acknowledge that families do need additional support and so we've included the Nest strategy in our resource, which was developed by the peak Reproductive Mental Health Programme to improve parents and caregivers wellbeing in the early years.

00:39:14:16 - 00:39:41:06

Unknown

Regarding the implementation of our resource in our updated messaging, we've engaged in a two phase implementation plan, part of it completed and phase one, including a webinar on development of health care provider facing web content and a social media campaign. Phase two will include a second and social media campaign resource feedback and the development of a shorter practise resource and updates to the indigenous, a safer sleep resource that we should.

00:39:41:19 - 00:40:05:24

Unknown

And in summary, we want to recognise that we across the entire continuum of care are all jointly responsible for safer infant sleep. We cannot leave it to families alone. It is not their sole

responsibility to bear And the evidence for this lies in the social determinants of health and the resulting health inequities that leave some families and some communities at risk of higher rates of infant deaths during sleep.

00:40:06:17 - 00:40:29:15

Unknown

In addition, the issue is too complex to share and rely on overly simplified one size fits all messaging. This doesn't create space for conversation and can lead to families being reluctant to discuss their sleep related questions and circumstances. We have cared for families that were told a simplified message to never sleep with their baby sorry in their bed.

00:40:30:00 - 00:40:52:02

Unknown

And so instead they took their baby to the couch and slept on the couch. And they were doing the best that they could with the simplified message that they'd received, but were unwittingly and unknowingly putting their baby at increased risk. 23 fold. Families need us to be open and honest and to share information about the risks and to share strategies for reducing those risks.

00:40:52:19 - 00:41:26:23

Unknown

For those that can breastfeed. They need to hear that breastfeeding is protective, and then they need their support to initiate and sustain lactation. In addition, families need our support to address alcohol, tobacco and other substance use and to nurture their mental health and well-being. Collectively, we can address safer infant sleep, and in many cases prevent devastating loss of life We'd like to take a minute to thank our provincial partners for their support and development of this updated resource, along with our national and international colleagues.

00:41:27:07 - 00:42:08:03

Unknown

For their commitment to exploring and developing evidence based, family centred approaches to safer sleep. We'd like to thank the DERM Infancy and Sleep Centre and recognise the important role that conferences like this play in supporting Safer Infants sleep as well. Thank you Thank you both for that really interesting talk. The I'm I'm really impressed at the way in which the safer sleep discussion and the tools available now are kind of moving on in different parts of the world.

00:42:08:03 - 00:42:31:05

Unknown

It's become much more sophisticated than it was even a few years ago. And I can remember going to being invited to go and speak in British Columbia probably about seven or eight years ago. When they were just at the beginning of the first tool. And now to see how it's all developed. It's it's amazing. So I know that Lisa and Leah have joined us online.

00:42:31:14 - 00:42:59:17

Unknown

So would you like to unmute yourselves and say, hi, ladies? Oh, hello from British Columbia. I'm in the interior right now, so thank you very much. It's wonderful conference. And that's been our privilege to be part of it. And it's just wonderful. So thank you. Thanks, Leah. And my colleague and my colleague Lisa I ask you to forgive me.

00:42:59:17 - 00:43:32:23

Unknown

I've lost my voice lately, so. Yes, good to have to work on this Q&A. That's a very good way to get out of it. I know. I was thinking that was great. Yeah, it was. All right then. So I see that people have already put some questions in the chat, and if anybody wants a copy of our resource, you can go on the Paronella Services ABC website and look up say, for instance, sleep and you can find the link there in all the background and the ordering process as well.

00:43:33:00 - 00:43:55:13

Unknown

If something you're interested in Fabulous. Thank you, Katherine. I'm not sure we can hear you. Come hear Katherine. Okay, I'm going to have to read it then. So Katherine's question was, what is the research around bottle feeding on breast milk? So we've talked about, you know, feeding formula. We've talked about breast sleeping, we've talked about formula and fed chair and talked about breast sleeping.

00:43:56:18 - 00:44:18:23

Unknown

What what did you guys find in the course of doing this about breast milk? What isn't delivered directly from the breast and breast sleeping? I think it's it's similar because it's it's not the it's not the product in the bottle. It's it's the it's often that the research shows that they often are lying prone or they prop up.

00:44:19:04 - 00:44:38:03

Unknown

And so they don't assume that that that at sea position, that instinctive sea position and the treatment is different as well. So I think that that's kind of what the literature sort of in a nutshell sort of supports. I think there's other people on here, but I think that that's in general it's not that it's the breast milk.

00:44:38:04 - 00:45:08:08

Unknown

Of course, breast milk has the additive protection, but it's usually that when families have chosen to feed infant formula and it's the mechanism and they often lie their babies prone or prop the bottles. So that's that's the, the mechanism part of it, I think. And I think that, you know, we need to talk to think about the, the physiology, the mum, what's happening to the mum's physiology when she's feeding at night versus when she's previously pumped.

00:45:08:08 - 00:45:28:02

Unknown

So it's the, it's, you know, the, the accumulation of milk during the night is one of the things that kind of prompts mums to arouse and more frequently and, and to feed frequently etc. and so when that milk is being delivered via the bottle, it's human and yeah yeah for sure. Yeah. That's a great question though. Thank you.

00:45:29:19 - 00:45:54:15

Unknown

But I don't think there's an awful lot of direct research around it about, you know, the way in which mums what. I know there's no research directly about the way in which mums who are feeding pumped breast milk are sleeping with their babies. That's all kind of us putting two and two together from other bits of information. Yeah, and I think I'd be interested to we, we also looked at there was a lack of information in the literature around mixed feeding as well.

00:45:54:17 - 00:46:16:19

Unknown

Right. Combination feeding. And so that's a piece of research that needs to be done. James or I think we have to let him go into retirement at some point. I don't think we can afford to force him to keep doing research for the rest of his life. But so yes, that was another piece. We couldn't make a comment.

00:46:16:19 - 00:46:39:12

Unknown

We had a lot of ask around that and in our jurisdiction around what is the evidence around next feeding and say for sleep hour. The little bit of evidence that we have accumulated here in Durham was that mums who had previously breastfed but weren't breastfeeding at the time we were filming them sleeping with our babies, slept like breastfeed us.

00:46:39:19 - 00:47:01:12

Unknown

So they remembered the kind of, you know, the, the way in which they they slept and they continued to kind of cuddle around their babies and do all of that kind of stuff. I like to think there's the blueprint of their biology and there's protective factors. So I would think that it would be more protective if they mixed feet than they did, and that would just be my assumption.

00:47:01:12 - 00:47:40:19

Unknown

But yeah, right. Lisa, could you put in the Chat Hawks her link to the conference? Go to our resource. Thank you. And I'm sure I I'm going to go to Noel now. Noel, do you want to unmute and ask your question about breastfeeding out of nipple shields or maybe lactation aids specifically the please, I think Kathy maybe could jump in our genes, but I haven't seen specific focussed target research on sleeping with the shield.

00:47:41:15 - 00:48:09:12

Unknown

I think it's a tool. So the attunement and the product and the transfer and you're out the breast still. So we know that probably I wouldn't, I, I don't know how that would be impactful to the overall sleep is the sleep safety issue. Unless, unless. Yeah, I'm not sure. Please jump in anybody else. But that's a very good question.

00:48:09:12 - 00:48:35:03

Unknown

I haven't had that actually actually. So since would be a little different because I'd be a little bit more tricky I think. But I think wow that's mothers are our breastfeeding parents are pretty amazing to be able to sleep and to do the snacks and and to attach and watch with a shield. And so I think I still think that you're probably going to assume the safety position, the seat position.

00:48:35:11 - 00:48:57:08

Unknown

And I assume that you're probably giving full human milk to your babies if if you're using snacks, perhaps. I'm not I'm not certain for sure about there's different scenarios with that. But I'll I'll pause there and let anybody else speak on it. Amanda, did you want to say something about using nipple shield? Even with the shield, is you still triggering a let down reflex?

00:48:57:08 - 00:49:20:03

Unknown

You still could be triggering the hormones. So I don't think she'll use per say is going to have any difference on any impact on sleep. And I think there was a study published in the last month that compared the volumes of milk with and without shields to be quite similar SRS a whole different ballgame to together depending whether a person is actually lactating or not.

00:49:20:13 - 00:49:41:18

Unknown

I've never used a nipple shield, so I don't know whether this is a reasonable question, but does it pose any risk to the baby if it if it cover its nose? So yes, I it that would be the only thing if it flipped forward or it got a. But that would be I mean, I don't know. There's another study how frequently does not happen to children.

00:49:41:19 - 00:49:58:01

Unknown

The mums when I was in nipple shields are doing it for a reason. So that getting up there, sitting in the feeding we typically find with older infants when they stop using nipple shields tends to be half way through the night when they take the nipple shield off and start feeding without and then show us some of the lactation consultants agree with me.

00:49:58:01 - 00:50:02:09

Unknown

We then get mums going baby won't use the nipple shield. What could I do? Can I see you again?

00:50:05:12 - 00:50:27:14

Unknown

This mother was using a nipple shield. They would have to wake up and ask to place it and get the baby left. So I don't know that we actually have it. I think we're on two things right now. Sorry if you bring an echo, I think that the mother would have to be awake and put the shield on and lets the baby to get them going.

00:50:27:14 - 00:50:47:07

Unknown

So I don't think there's been any specific research. I don't think Jim's done any. I mean, he can speak to that, but I think what the rest of you are saying is it's probably what happens. Yeah, I think there's that cascade, the hormone cascade, which is that protective piece, and that occurs But yeah, those are great questions. Thank you, everybody.

00:50:47:19 - 00:51:12:06

Unknown

Okay, we've got another one here, which is from Jenny. Jenny, are you feeling up to one muting and asking your question yes, I'm here. I was just completely forgot my ask them sleep training and sleep asking the definition of sleep training because I know there's a lot of discussion between parents as to what is or isn't sleep training they built.

00:51:12:12 - 00:51:46:12

Unknown

So what we're doing is like, you know, like encouraging sleep or sleep guidance rather than sleep training. So it can be a bit of a grey area. Yeah. So we wrote a section out about commercial sleep training programmes and sort of a brief definition and summary of that within our jurisdiction and how we've defined it. And so it's probably easier for you to look it up in our resource, but we don't define sleep training as sleep training aims to increase the length of time infants sleep through the night without disturbance.

00:51:46:12 - 00:52:08:23

Unknown

So that's a summary. It's kind of a general definition which we know is depending on when that's occurring and usually in the early days can further put the infant at risk in those critical time periods. But feel free to have a look at the resource I think Lisa has put the link to our resource in the chart. Fabulous.

00:52:08:23 - 00:52:44:20

Unknown

Thank you. We've got a question in the room I've always been really interested in the smoking in pregnancy, so if this smoking cessation early on postnatal a is the risk still is. I mean it's not going to be as great, but is the risk still there? Are they to be not included in the selection of mothers who are

okay to bed share if the breastfeed and because you very often find that you know antenatal they cut down well actually the cessation happens post-natal.

00:52:45:08 - 00:53:04:22

Unknown

Okay Lisa and Leah, do you want to answer that. I do want me to have a go. You know what I'll turn it over to you probably have the evidence a little bit more defined okay. There's two parts to that question. The right so so that the if a baby is smoke exposed in utero, it has blunted arousal ability.

00:53:05:05 - 00:53:27:09

Unknown

So that's the simple answer. So you can't reverse that after birth. So the baby is still vulnerable in that sense. It's if the mum stop smoking subsequently, then that is not you know, it's not going to have an added increased risk of the postnatal smoke exposure, but it's the, it's the exposure in utero that is the, the biggest issue Okay.

00:53:27:09 - 00:53:56:05

Unknown

Any other questions? Have I missed anything in the chat I think there was a questionnaire in the chat around we do need harm reduction for bottle feeding families. I agree they're at risk for sure. And something that we're also looking at in discussion in our secondary or our compendium resource that we'll be developing for our acute care settings Okay.

00:53:56:08 - 00:54:04:10

Unknown

Thank you all very much. That was a very great, great talk and a lovely discussion. So certainly I thank you for joining us for that.